DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YGL3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00120

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245398**

2.STATE VENDOR OR MEDICAID NO.
(L2) **187918900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKER OAKS COMMUNITIES INC**
(L4) **211 6TH STREET NORTHWEST**
(L5) **WINNEBAGO, MN** (L6) **56098**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/20/2006**

6. DATE OF SURVEY **04/20/2012** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Maria King, Unit Supervisor 05/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 05/21/2012 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/11/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

On April 20, 2012, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on April 11, 2012, The Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the March 1, 2012 standard survey, effective April 20, 2012. Refer to the CMS-2567b for both health and life safety code.

Effective April 20, 2012, the facility is certified for 45 skilled nursing home beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5398

May 21, 2012

Ms. Dorothy Baker, Administrator
Parker Oaks Communities Inc
211 6th Street Northwest
Winnebago, Minnesota 56098

Dear Ms. Baker:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 20, 2012 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4118 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 2, 2012

Ms. Dorothy Baker, Administrator
Parker Oaks Communities Inc
211 6th Street Northwest
Winnebago, Minnesota 56098

RE: Project Number S5398023

Dear Ms. Baker:

On March 16, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 1, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 20, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 11, 2012 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 1, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 20, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 1, 2012, effective April 20, 2012 and therefore remedies outlined in our letter to you dated March 16, 2012, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Maria King

Maria King, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 344-2716 Fax: (507) 344-2723

Enclosure

cc: Licensing and Certification File 5398r12.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245398	A. Building B. Wing	4/20/2012

Name of Facility	Street Address, City, State, Zip Code
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **04/19/2012**	ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **04/19/2012**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **04/19/2012**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/19/2012**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/19/2012**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **04/19/2012**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/20/2012**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/MK	05/02/2012	08769	04/20/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/1/2012			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245398	01 - MAIN BUILDING 01	4/11/2012

Name of Facility	Street Address, City, State, Zip Code
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0017	Correction Completed **03/20/2012**	ID Prefix Reg. # **NFPA 101** LSC K0052	Correction Completed **03/20/2012**	ID Prefix Reg. # **NFPA 101** LSC K0144	Correction Completed **03/30/2012**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** MM/PS	**Date:** 05/2/2012	**Signature of Surveyor:** 22373	**Date:** 04/11/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 2/28/2012		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**		**YES** **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YGL3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00120

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245398**
2.STATE VENDOR OR MEDICAID NO.
(L2) **187918900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKER OAKS COMMUNITIES INC**
(L4) **211 6TH STREET NORTHWEST**
(L5) **WINNEBAGO, MN** (L6) **56098**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/20/2006**

6. DATE OF SURVEY **03/01/2012** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
At the time of the March 1, 2012 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Mary Whitlock, HFE NEII — 04/09/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Program Specialist — 04/10/2012 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Uploaded 04/11/12 DB YGL3

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 6094

March 16, 2012

Ms. Kyla Jacobs, Administrator
Parker Oaks Communities Inc
211 6th Street Northwest
Winnebago, Minnesota 56098

RE: Project Number S5398023

Dear Ms. Jacobs:

On March 1, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Maria King
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001

Telephone: (507) 344-2716

Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 25, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 25, 2012 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 1, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 1, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Maria King, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 344-2716 Fax: (507) 344-2723

Enclosure

cc: Licensing and Certification File 5398s12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245398	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure restraints were utilized in the least restrictive manner and to treat a resident's medical symptoms for 1 of 3 residents (R7) reviewed who utilized a lap buddy. Findings include: R7 utilized a lap buddy while seated in her wheelchair without regular opportunities for removal, and without any assessement of the resident's medical symptoms. R7 had been admitted to the facility on 7/9/10 with diagnoses that included: generalized	F 221	F221 - Resident R7's lap buddy is to be discontinued with family agreement on 3-23-12 and a ½ tray table ordered on 3-27-12 is to be applied to be less restrictive. A comprehensive assessment will be done on the use of this device. Any restrictive devices that may be requested by family or residents will be assessed prior to application by the nursing department and the IDT. Nursing staff will be in-serviced on 4-12-12 regarding this system. The facility will track any restrictive devices and assessments will be done on their need and effectiveness. Restrictive devices will be reported at QA&A for discussion.	4-19-12

Approved 4/9/12 MK 08769

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dorothy Baker	Administrator	4-2-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Minnesota Dept of Health
Mankato

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	245398	A. BUILDING _____ B. WING _____	03/01/2012

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F 221	Continued From page 1 weakness and dementia. During an observation at 11:53 a.m. on 2/27/12, R7 was observed seated in her wheelchair with a lap buddy across her lap. During interview with the DON (Director of Nursing) at 1:24 p.m. on 2/27/12, the DON stated that R7 utilized a lap buddy whenever seated in the wheelchair because her family had requested it. Record review revealed the initial order for the lap buddy had been received on 11/30/11 after the family had requested it. There was no assessment documentation in the resident's record to identify the medical symptoms for the use of the restraint, or to ensure the least restrictive device was utililzed. A facsimille (fax) document had been submitted to the resident's physician on 1/26/12 from the DON. The fax indicated the resident's lap buddy had been discontinued on 1/26/12 as it was "no longer indicated." The physician had signed the order on 1/27/12. An interdisciplinary team note dated 1/30/12, documented by a licensed practical nurse included: "...Family member...verbalized she was upset that her mom did not have her lap buddy in position. We applied lap buddy and the problem was solved." Subsequently on 1/30/12, a physician's order was received to "reinstate lap buddy continuous (except repositioning) while up in chair." The DON was interviewed at 5:03 p.m. on 2/29/12, she verified that on 1/26/12 she had sent the physician a fax requesting the discontinuance of the lap buddy for R7 as it was no longer	F 221		

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F 221	Continued From page 2 indicated. The DON stated that R7 had no medical necessity for the use of a physical restraint however, confirmed that on 1/30/12 an order had been received to re-instate the lap buddy. The DON further verified that no physical restraint assessment had been completed to identify the appropriateness of the physical restraint for R7. She stated that R7 required 2 persons to assist with transfers. The DON stated that R7 never tries to get out of the wheelchair, adding that the order had been reinstated only because the family had requested it. When asked why the daughter wanted the lap buddy, the DON stated she was unsure.	F 221		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess physical restraints for 1 of 3 residents (R7) who utilized lap buddy restraints; and failed to comprehensively assess risk factors and interventions for 1 of 3 residents (R24) in the sample who experienced frequent falls. Findings include: There had been no comprehensive assessment of R7's need for the use of a lap buddy while seated in her wheelchair. Consequently, there	F 276	F276 – The lap buddy for resident R7 has been discontinued and a comprehensive assessment to be completed for a half tray table when applied. Resident R24 comprehensive assessment will be completed as necessary. All third floor residents will be reassessed in regards to proper restraints/safety devices to ensure least restrictive. All quarterly MDS's that are due on or after 4-12-12 will be audited to ensure proper assessment/evaluations have been completed. Staff will be in-serviced on 4-12-12 on proper use if restraints and assessments that are needed before applying. This audit will be completed by the DON or her designee. Results of the audits will be presented to QA&A.	4-19-12

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F 276	Continued From page 3 was no assesment of medical symptoms and/or less restrictive options or use. The quarterly MDS (Minimum Data Set) dated 1/13/12, verified that R7 utilized a restraint that prevented rising on a daily basis. R7 had been admitted to the facility on 7/9/10 with diagnoses that included: generalized weakness and dementia. During an observation at 11:53 a.m. on 2/27/12, R7 was observed seated in her wheelchair with a lap buddy across her lap. During interview with the DON (Director of Nursing) at 1:24 p.m. on 2/27/12, the DON stated that R7 utilized a lap buddy whenever seated in the wheelchair because her family had requested it. Record review revealed the initial order for the lap buddy had been received on 11/30/11 after the family had requested it. There was no assessment documentation in the resident's record to identify the medical symptoms for the use of the restraint, to ensure the least restrictive device was utililzed. A facsimille (fax) document had been submitted to the resident's physician on 1/26/12 from the DON. The fax indicated the resident's lap buddy had been discontinued on 1/26/12 as it was no longer indicated. The physician had signed the order on 1/27/12. An interdisciplinary team note dated 1/30/12, documented by a licensed practical nurse included: "...Family member...verbalized she was upset that her mom did not have her lap buddy in position. We applied lap buddy and the problem	F 276		

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F 276	Continued From page 4 was solved." Subsequently on 1/30/12, a physician's order was received to "reinstate lap buddy continuous (except repositioning) while up in chair." The DON was interviewed at 5:03 p.m. on 2/29/12, she verified that on 1/26/12 she had sent the physician a fax requesting the discontinuance of the lap buddy for R7 as it was no longer indicated. The DON stated that R7 had no medical necessity for the use of a physical restraint however, confirmed that on 1/30/12 an order had been received to re-instate the lap buddy. The DON further verified that no physical restraint assessment had been completed to identify the appropriateness of a physical restraint for R7. She stated that R7 required 2 persons to assist with transfers. The DON stated that R7 never tries to get out of the wheelchair, adding that the order had been reinstated only because the family had requested it. When asked why the daughter wanted the lap buddy, the DON stated she was unsure. R24 had experienced frequent falls without comprehensive assessment of causative factors to determine appropriate interventions. R24 had been admitted to the facility on 1/14/06 with diagnoses that included: dementia, depression, closed dislocation of the shoulder, fracture of the left femoral neck and fracture of the proximal humerus. R24 had experienced incidents documented as having occurred as follows: 9/3/11 at 6:50 p.m. the resident was found sitting on the dining room floor.	F 276		

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F 276	Continued From page 5 10/8/11 at 2:40 p.m. the resident ws observed in the hall on her hands and knees, and lowered herself to a lying position. 10/18/11 9:45 a.m. the resident was observed on the floor on the side of her recliner chair with the chair tipped backwards. 11/16/11 4:30 a.m. the resident was found on the floor by the side of her bed. 2/16/12 (time not specified) the resident had an "unwitnessed fall." The documentation details from these incidents indicated the resident had attempted self-transfers at varying times of the day for each of these falls. Interventions for implementation were documented following four of the falls including: remind resident to use the call lite for assistance, 30 minute checks, low bed and alarms, however, these the resident's record revealed these same interventions had been in place prior to the falls. The facility had not conducted any comprehensive assessment to determine causative factors nor assessment of new interventions to determine appropriateness for implementation. A quarterly MDS dated 1/27/12, indicated R24 had memory and recall problems. The MDS further identified the resident as requiring supervision of staff with transfers, walking in room and off the unit, as being unsteady with balance during transition and walking, and as having experienced falls with injury (non-major) since the prior quarterly assessment (10/28/11). Further review of the medical record identified the resident as having experienced a change in mobility; she had declined from independent to requiring supervision of 1 assist with transfers	F 276		

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F 276	Continued From page 6 and walking since the last quarterly MDS. Fall risk assessment data dated 7/30/11 and 1/24/12, indicated the resident's risk score had increased from 14 to 16 (with a score of 10 or greater indicating high risk for falls). During Interview with the DON (director of nursing) at 2:30 p.m. on 3/1/12, she confirmed there had been no comprehensive assessment of the causal factors of the falls, nor had there been assesment of any new interventions for implementation following R24's falls. The facility's policy, Incident Policy and Procedure dated 11/11/11, included: "...overall goal of fall prevention is to minimize fall risk by eliminating modifiable risk factors while maintaining or improving the individual's mobility and autonomy resulting in minimized injury, and reduction in number of falls while respecting the individual's freedom to be mobile." In addition, the policy identified that each incident would be "analyzed by the RN (registered nurse) or ADON (assistant director of nursing) and all falls will be discussed by the fall committee. All interventions will be looked at and discussed."	F 276		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312	F 312 - Resident R12 has passed away since the survey. Nursing staff will be in-serviced on 4-12-12 as to proper personal hygiene procedures for all residents. A nurse will sign off that all proper ADLs were performed. Visual checks/audits will be performed by the DON or designee on all residents weekly for 4 weeks to ensure compliance. Audit results will be brought to QA&A.	4-19-12

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F 312	Continued From page 7 Based on observation, interview and policy review, the facility failed to ensure nail care was provided for 1 of 3 residents in the sample (R12) reviewed for activities of daily living who were dependent on staff to meet their needs. Findings include: During observation of R12 at 10:55 a.m. on 2/27/12, it was noted that his fingernails were soiled at the cuticle around the base of the nails and under his fingernails. During an additional observation at 8:15 a.m. on 2/29/12, R12's fingernails remained soiled. Review of a readmission MDS (minimum data set) dated 1/19/12, revealed that R12 required extensive assistance of staff to meet his grooming needs. Review of the corresponding CAA (care area assessment) dated 1/24/12, confirmed that R12 was totally dependent on staff for the provision of care to meet his activity of daily living needs. Additional record review revealed a note by a nursing assistant that R12's nails had been cleaned on 2/22/12. There had been no further documentation after 2/22/12 regarding the resident's nail care. Interview with the director of nursing on 2/29/12, at 1:30 p.m. confirmed that resident nails should be cleaned on the resident's bath days, but should also be cleaned as needed. She stated she expects staff to monitor nails with morning and bedtime cares. The facility's CARE of FINGERNAILS policy and procedure, dated 2010, identified: "It is the policy of Parker Oaks Communities, Inc.(incorporated) to ensure that all residents of this facility receive proper nail care on a regularly scheduled basis." The policy further included, "...Proper nail care can reduce the transmission of disease because	F 312		

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F 312	Continued From page 8 the hands and feet are often exposed to many microorganisms which can grow quickly in the nail beds. This procedure will also help the patient to remain comfortable and allow you to look for signs of infection that can lead to complications."	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure side rail equipment was maintained in a safe manner for 1 of 3 residents in the sample (R18) reviewed for accident hazards; and failed to adequately assess risks and interventions for 1 of 3 residents in the sample (R24) who experienced frequent falls. Findings include: During observation of the side rails on R18's bed at 11:34 a.m. on 2/27/12, it was noted that the side rails were very mobile. When in the elevated position, the side rails moved easily five to six inches toward the head and foot of the bed and also moved five to six inches laterally. Interview with R18 at this same time confirmed that he utilized the eleveated side rails when he was in bed at night to assist with changing his position in	F 323	F323 – Resident R18 has new ½ side rails on his bed. Resident R24's low bed has been d/c and new assessments to be completed. 30 minute safety observation initiated on 3-29-12 and will continue until IDT determines resident's safety is ensured. All residents who require ½ side rails for mobility will be reassessed for safety and to ensure that proper interventions are in place. Staff will be in-serviced on 4-12-12 regarding the proper system to be implemented. The DON or designee will reassess/audit for proper interventions and report findings to the QA&A.	4-19-12

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F 323	Continued From page 9	F 323		

the bed. The side rails continued to be loose when elevated on 2/29/12 at 2:00 p.m.
The resident's record was reviewed and revealed R18 had experienced no incidents related to the use of the side rails.
During interview with the maintenance director at 2:15 p.m. on 2/29/12, he stated that the rails on R18's bed were a " universal rail " style. He stated that the rails had fit tightly when he had placed them on the resident's bed. At the time of the interview he observed R18's rails and confirmed the side rails were loose and should not be as mobile as they were. The maintenance director stated he thought the rails had loosened up over time with use. He stated that when staff had noted that the side rails were loose, a requisition should have been made for him to look at the side rails. He verified he had not received a work requisition related to R18's side rails. He also stated this particular style of side rails was not scheduled for routine maintenance checks for safety.
R24 had experienced frequent falls without comprehensive assessment of risk factors to determine appropriate interventions.

R24 had been admitted to the facility on 1/14/06 with diagnoses that included: dementia, depression, closed dislocation of the shoulder, fracture of the left femoral neck and fracture of the proximal humerus.

R24 had incidents documented as having occurred as follows:

9/3/11 at 6:50 p.m. the resident was found sitting on the dining room floor.
10/8/11 at 2:40 p.m. the resident was observed in

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F 323	Continued From page 10 the hall on her hands and knees, and lowered herself to a lying position. 10/18/11 9:45 a.m. the resident was observed on the floor on the side of her recliner chair with the chair tipped backwards. 11/16/11 4:30 a.m. the resident was found on the floor by the side of her bed. 2/16/12 (time not specified) the resident had an "unwitnessed fall." The documentation details from these incidents indicated the resident had attempted self-transfers at varying times of the day for each of these falls. Interventions for implementation were documented following four of the falls including: remind resident to use the call lite for assistance, 30 minute checks, low bed and alarms, however, these the resident's record revealed these same interventions had been in place prior to the falls. The facility had not conducted any comprehensive assessment to determine causative factors nor assessment of new interventions to determine appropriateness for implementation. A quarterly MDS dated 1/27/12, indicated R24 had memory and recall problems. The MDS further identified the resident as requiring supervision of staff with transfers, walking in room and off the unit, as being unsteady with balance during transition and walking, and as having experienced falls with injury (non-major) since the prior quarterly assessment (10/28/11). Further review of the medical record identified the resident as having experienced a change in mobility; she had declined from independent to requiring supervision of 1 assist with transfers and walking since the last quarterly MDS. Fall risk	F 323		

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F 323	Continued From page 11 assessment data dated 7/30/11 and 1/24/12, indicated the resident's risk score had increased from 14 to 16 (with a score of 10 or greater indicating high risk for falls). R24's current care plan identified a problem of "alteration in comfort and mobility related to history of falls resulting in a left hip fracture, left humerus fracture and dislocated shoulder." Interventions included: "stand by assistance with transfers and ambulation, use of walker for all transfers and ambulation, staff to monitor for unsteadiness, ambulate several times a day, reminders to use the call lite for assistance, chair/ bed alarm and low bed." The care plan also indicated R24 had a problem with alteration in her mental status as evidenced by her dementia. Additional review of the resident's medical record revealed that the resident had not been evaluated by Physical or Occupational Therapy Services since admission. During interview with NA (nursing assistant)-D at 10:05 a.m. on 3/1/12, NA-D confirmed that R24 does make attempts during the day to stand from her low bed. She stated the resident scoots to the end of her bed, grabs onto the footboard, and is occasionally able to get herself up. NA-D added that R24 is very unsteady. During Interview with the DON (director of nursing) at 2:30 p.m. on 3/1/12, she confirmed there had been no comprehensive assessment of the causal factors of the falls, nor had there been assessment of any new interventions for implementation following R24's falls.	F 323		

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F 323	Continued From page 12 The facility's policy, Incident Policy and Procedure dated 11/11/11, included: "...overall goal of fall prevention is to minimize fall risk by eliminating modifiable risk factors while maintaining or improving the individual's mobility and autonomy resulting in minimized injury, and reduction in number of falls while respecting the individual's freedom to be mobile." In addition, the policy identified that each incident would be "analyzed by the RN (registered nurse) or ADON (assistant director of nursing) and all falls will be discussed by the fall committee. All interventions will be looked at and discussed."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 – Resident R3's Xanax has been d/ced and a sleep study performed. Resident R16 has been assessed by physician and a clinical rational received for GI meds. The IDT will review the Pharmacy Consultant's report for possible changes as recommended. Changes will then be addressed with the resident's physician. Nursing staff will be in-serviced on 4-12-12 on proper procedure on multiple medication use. DON and Administrator will audit the review of Pharmacy Reports. Audit findings will be reported to QA&A.	4-19-12

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	245398	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

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F 329	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to adequately identify, assess, and monitor clinical indications for continued use of medications for 2 of 10 residents (R3 and R16) whose medications were reviewed.. Findings include: R3 routinely received Xanax, a psychoactive medication, without assessment and monitoring of the medication's efficacy being monitored. R3 was admitted to the facility on 11/18/11 with diagnoses including: confusion with senility; history of depression; vertigo (dizziness), and insomnia. The current physician orders identified that Xanax 0.25 mg (milligrams), had been initiated at the time of admission to be given orally at bedtime for the diagnosis of insomnia. Review of the resident's record revealed no sleep assessment had been conducted to determine the efficacy of the medication use. During interview with the DON (Director of Nursing) at 5:05 p.m. on 2/29/12, she verified that no sleep study or sleep assessment has been completed nor was the staff documenting the number of hours the resident slept to determine effectiveness of the medication.	F 329		

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F 329	Continued From page 14 R16 received 4 gastrointestinal medications and lacked clinical indications for use and monitoring of the medication's effectiveness. Review of the resident record revealed R16 had been admitted to the facility 11/15/11 with diagnoses that included esophageal diverticula and esophageal reflux. The physician's order indicated R16 received Protonix 40 mg daily, Mylanta 30 ml (milliliters)twice daily, Zantac 150 mg twice daily, and Reglan 10 mg twice daily. According to the consultant pharmacist's (RPH) drug review report dated 12/15/11, the RPH had identified the duplicate therapy and recommended the physician consider a discontinuation of medication if appropriate, "particularly the Reglan which is a high risk medication." The physician's documented response included only, "no change." The use of these medications was not addressed on the resident's care plan and there was no documentation of monitoring the efficacy of the medications. During interview with the DON at 11:00 a.m. on 3/1/12, she verified the lack of clinical rationale for the duplicative therapy, and the lack of monitoring to determine efficacy of the medications. During interview with the RPH at 1:15 p.m. on 3/1/12, he verified the physician had not provided rationale for the continued use of all 4 medications used to treat gastrointestinal issues.	F 329		
F 412	483.55(b) ROUTINE/EMERGENCY DENTAL	F 412		

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F 412 SS=D	Continued From page 15 SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to arrange for dental services for 1 of 3 residents in the sample (R18) reviewed for dental status. Findings include: During an interview with R18 at 11:26 a.m. on 2/27/12, the resident stated that he had teeth that needed to be pulled. He stated that he knew he would have to go to a neighboring town, but he did not think an appointment had been made. The resident's record was reviewed. An annual minimum data set (MDS) information dated 1/13/12, indicated R18 had obvious broken or carious teeth. The corresponding care area assessment (CAA) dated 1/20/12, identified that R18 was able to brush his teeth after set up and needed encouragement to do so. The CAA further included information that R18 had several broken teeth observed during a visual assessment of his oral cavity. The record included a note written at the time of the resident's care conference on 1/31/12, which	F 412	F 412 - Resident R18 has received dental care and appropriate teeth have been extracted. A dental schedule will be revised to ensure that other residents will not miss timely dental appointments. Nursing staff will be in-serviced on 4-12-12 to ensure that Social Services and family are notified of appointments. DON or designee will audit that dental appointments are being scheduled and attended as appropriate. Audit reports will be brought to QA&A for review.	4-19-12

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F 412	Continued From page 16 indicated R18 had agreed to see a dentist at that time due to his poor dentition. The note further stated that a nurse would be informed so she could make an appointment. Review of the nurses' notes and consultation notes revealed no documentation to indicate that an appointment had been arranged, or that R18 had seen the dentist following the care conference discussion. Interview with the social services director (SSD) on 2/28/12 at 12:35 p.m., confirmed that R18 had not seen the dentist following the concern identified at his care conference. The SSD stated that no appointment had been made by the nursing staff. She stated that she would make some calls to start the process following discussion with the surveyor.	F 412		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	F 441 - Resident R 12 has passed away since our survey. All staff will be reeducated regarding facility wide infection control programs, preventing the spread of infections and proper linen handling on 4-19-12. Random visual audits will be conducted by IDT members and results presented at QA&A.	4-20-12

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F 441	Continued From page 17 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow infection control practices for 1 of 1 resident (R12) with an active Clostridium (C) difficile infection. Findings include: During observation of cares for R12 on 2/29/12, at 7:30 a.m. NA (nursing assistant)-A and NA-B were observed in the resident's room assisting him off the bed pan. R12 was observed to have had a small amount of loose stool in the bed pan. Both of the NA's were observed wearing latex gloves, however neither of the staff was wearing a protective gown. The same two nursing assistants entered R12's room again at 9:00 a.m. on 2/29/12. R12 had	F 441		

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F 441	Continued From page 18	F 441		

been incontinent of a large, loose bowel movement. NA-A and NA-B were observed to put on protective gowns and latex gloves. NA-A was observed to use wet wipes to clean R12's rectal area and buttocks. Without changing her gloves and washing her hands, she then touched the resident's side rails on the bed. NA-A was observed to go to the resident's closet and get out a tube of barrier cream. She opened the barrier cream and squeezed some cream onto the gloved hand of NA-B. NA-B was observed to put barrier cream onto R12's buttocks and rectal area. NA-B then wiped the excess barrier cream onto a disposable pad from R12's bed. Without removing their gloves and washing their hands, both staff assisted R12 to put on his shirt. NA-B adjusted R12's bed using the electronic controls. NA-A moved the privacy curtain while her wearing her soiled gloves and then grabbed the over bed table and moved it closer to the resident. NA-A was observed to grab the resident's breakfast plate and hold it up so R12 could reach his bacon. NA-A returned the plate to the plate warmer on the resident's tray that was on the over bed table. NA-A was observed to pick up soiled wipes and some washcloths that had been placed on the carpeted floor at the foot of the bed during the incontinent cares. She put them in containers in R12's room. R12 then asked to have Bengay applied to his toe. NA-A went to R12's closet and got a tube of Bengay out of a drawer and rubbed some on the resident's left great toe. R12 requested socks, so NA-A went to the drawer and got out socks for the resident and put them on the resident. NA-A and NA-B then removed their gowns and gloves and disposed of them in the trash in R12's room. The staff walked across the hall to another resident's room and

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F 441	Continued From page 19 washed their hands. At 11:30 a.m. on 2/29/12, NA-C was observed in R12's room assisting him off the bed pan. She wore a protective gown and latex gloves. She was observed to wipe R12's buttocks with a wet wipe. R12 was observed to have had a small amount of stool in the bed pan. NA-C threw the wipe into the trash and removed her gloves. She then went into the resident's bathroom, that was shared with another resident, and retrieved gloves. NA-C was observed to put on the new pair of gloves without washing her hands. She returned to the resident's room, opened the closet door, adjusted the over bed table and privacy curtain, and bagged the bed pan. She removed her gown and gloves and placed them in the trash in the resident's room. She then took the bed pan to the utility room and used the sprayer to clean the bed pan. She did not wear a protective gown when she sprayed the bed pan clean. Record review revealed that R12 had been hospitalized from 1/16/12 to 1/19/12 for intravenous antibiotic treatment to treat cellulitis. On readmission to the facility, the resident was receiving treatment for C-difficile, a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon. A recent stool specimen tested on 2/24/12 confirmed that R12 continued to have an active infection present in his stool. During interview with the director of nursing (DON) and the assistant director of nursing (ADON) at 1:30 p.m. on 2/29/12, they confirmed that R12 continued to have an active C-difficile	F 441		

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F 441	Continued From page 20 infection. Both the DON and the ADON confirmed that staff had not followed proper infection control practices when caring for R12 as described above. The DON stated that staff had been trained in proper infection control techniques related to the C-difficile when R12 had been readmitted to the facility. The DON stated staff had been trained following guidelines that had been found on the web site of the Centers for Disease Prevention and Control (CDC), and that the above care had not followed those infection control guidelines. According to information available from the CDC, the C-difficile infection is shed in feces. "Any surface, device, or material that becomes contaminated with feces may serve as a reservoir for the Clostridium difficile spores. Clostridium difficile spores are transferred to patients mainly via the hands of healthcare personnel who have touched a contaminated surface or item." The guidelines further indicated that facilities should use contact precautions when caring for patients with an active infection. This would include using gloves when entering patients' rooms and during patient care. The guidelines included: "Perform hand hygiene after removing gloves. Use of soap and water is more efficacious than alcohol-based hand rubs. Use gowns when entering patient's rooms and during patient care."	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5398020

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FORM APPROVED
OMB NO. 0938-0391

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety on February 28, 2012. At the time of this survey, Parker Oaks Communities Inc. was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division	K 000	POC ok 4-9-12 RECEIVED APR - 5 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

4-25-12 DC. EXIT: 3-1-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dorothy Baker	Administrator	4-2-2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 444 Cedar St., Suite 145 ST. Paul, MN 55101-5145 Pat.Sheehan@state.mn.us Fax: 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Parker Oaks Communities Inc. is a 3-story building with full basement. The building was constructed in 1965 and was determined to be of Type II(111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 33 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance	K 017		

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K 017	Continued From page 2 rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations, the facility has a use area which was not separated from the corridors in accordance with NFPA 101 (2000 edition), Chapter 19, Section 19.3.6.1. In a fire emergency, this deficient practice could adversely affect 18 of 45 residents, staff and visitors. FINDINGS INCLUDE: On 2/28/12 between 9:30 AM and 12:30 PM, it was observed that The Patio Lounge was equipped with two (2) doors which opened onto an egress corridor. Neither of these doors were equipped with positive latching hardware. As such, The Patio Lounge was a space open to the corridor system, and the space was not protected with an electrically supervised automatic smoke detector and did not meet the requirements at	K 017	A smoke detector was installed on March 20, by First Choice Alarm Company, in the Patio Lounge. This detector was installed to meet the requirements as sated in the correction orders.	3-20-12

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K 017	Continued From page 3 NFPA 101 (2000), Chapter 19, Section 19.3.6.1, Exception No. 6 (a). This finding was confirmed with the chief building engineer at the time of discovery.	K 017		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation, the facility's fire alarm system was not installed in conformance with NFPA 101 (2000), Chapter 19, Section 19.3.4 and Chapter 9, Section 9.6.1.4 and NFPA 70 (1999) and NFPA 72 (1999). In a fire emergency, this deficient practice could adversely affect 20 of 45 residents, staff and visitors. FINDINGS INCLUDE: On 2/28/12 between 9:30 AM and 12:30 PM, observation revealed two (2) smoke detectors installed in the C-200 Corridor, which were located within 3-feet of HVAC return air openings and/or supply air diffusers.	K 052	On March 20, First Choice Alarm Company moved the smoke detectors to meet the minimum 3 foot requirement distance form the HVAC.	3-20-12

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PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 4 This arrangement was not in accordance with the requirements at NFPA 72 (1999) Chapter 2, Section 2-3.6.6.2. These findings were confirmed with the chief building engineer at the times of discovery.	K 052		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Generators must be inspected weekly and exercised under load at not less than 30% of the EPS nameplate rating, for 30 minutes per month and shall be in accordance with NFPA 99 (1999 edition) and NFPA 110 (1999 edition). FINDINGS INCLUDE: On 2/28/12 between 9:30 AM and 12:30 PM, it was confirmed the facility's emergency generator was located outdoors, and this EPS equipment location was not equipped with battery-powered emergency lighting, in accordance with NFPA 110 (1999) Chapter 5, Section 5-3.	K 144	An illumination batter pack to provide emergency lighting is to be installed the week on March 26. Electrical Solution will install a batter pack in the facility that will connect to the outside area that needs to be illuminated.	3-30-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245398	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER OAKS COMMUNITIES INC	211 6TH STREET NORTHWEST WINNEBAGO, MN 56098

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 5 In an emergency evacuation situation, this deficient practice could adversely affect 45 of residents, staff and visitors.	K 144		